

Arkansas Department of Human Services
Division of Child Care and Early Childhood Education
Child Care Assistance Program

CHANGE REPORT

Casehead Name _____ Social Security No. _____ County _____ Date of Change _____

Check the appropriate box indicating type of change and complete all information in that section.

☐ **Personal Information**

Address _____ City _____ Zip _____ Hm Phone _____ Work Ph _____

☐ **Child Care Provider** *(One week's advance notice is required. New provider must complete a Child Care Arrangement Verification Form available from your child care caseworker.)*

Name of New Child Care Provider _____ Facility/License No. _____ Address _____ City _____

☐ **Household Status:** Describe change in household: _____

☐ **Employment:** ☐ No longer employed ☐ Took new job ☐ Increase/decrease (circle one) of hours to _____ per week

Name and Address of New Employer: _____

☐ **Income:** Increase/Decrease (circle one) in income to \$_____ received ☐ weekly ☐ every 2 weeks ☐ twice monthly
How many hours do you work per week? _____ ☐ monthly

☐ **School:** ☐ Dropped class(es). I am now taking _____ hours. ☐ No longer attending school as of _____

☐ **Other** (explain): _____

By my signature below, I certify all information given on this form in true and correct. I understand that giving false information or withholding information may result in criminal prosecution. I understand I will be responsible for any overpayment resulting from changes in my status.

Signed _____ Date _____

IN ORDER TO ENSURE CHANGES ARE RECEIVED, YOU MUST MAIL OR FAX THIS FORM DIRECTLY TO YOUR CHILD CARE SPECIALIST OR HAND DELIVER TO THEM. *NOTE: CHANGE FORMS FROM OTHER PROGRAMS ARE NOT VALID FOR CHILD CARE CASES.*

COMMENTS/NARRATION (DHS Use Only):

